STATE OF IDAHO
BUREAU OF OCCUPATIONAL LICENSES
1109 Main Street, Suite 220
Boise, Idaho 83702-5642

EVALUATION AND VERIFICATION OF SUPERVISED EXPERIENCE

Applicant _____ is seeking licensure to practice Counseling / Marriage & Family Therapy in the State of Idaho. The Idaho Board requires the information below in order to evaluate the extent and quality of the applicant's supervised experience.

SECTION 1 - To be completed by applicant: **(this page must be submitted to Supervisor with page 2)**

A. Name of supervisor _____

B. Address of supervisor _____

C. The setting of this supervision was (mark with an X **one only**):

☐ WORK ☐ PRACTICUM ☐ INTERNSHIP

D. Hours were gained as (mark with an X **one only**):

☐ GRADUATE ☐ POST-GRADUATE

E. Experience was earned in the following area/s (mark with an X **all that apply**):

☐ Mental Health ☐ Career Counseling ☐ Substance Abuse
☐ Marriage and Family ☐ Gerontology ☐ School Counseling
☐ Other. Please specify _____

F. Dates of practice by applicant at this setting: from _____ to _____

G. Total number of supervised practice clock hours during period listed in E above: _____

H. Total number of direct client contact hours during the period listed in E above: _____

If Marriage & Family Therapy, the total number of direct contact hours with families & couples _____

I. Number of face to face, individual, (not group) hours with supervisor during period listed in F above: _____

If Marriage & Family Therapy, the total number of group supervision hours (100 hours max) _____

J. Please describe the nature of the applicant's duties: _____
_____
_____

K. Please describe the nature of the supervision provided: _____
_____
_____

_____
Applicant Signature

State of _____, County of _____, ss.
Subscribed and sworn before me this _____ day of _____, 20 _____.

_____
(seal) Notary Public official signature
commission expires_____

EVALUATION AND VERIFICATION OF SUPERVISED EXPERIENCE
(continued)

SECTION 2 - To be completed by the supervisor: (do not complete without reviewing page 1)

Title at time of supervision _____

Title of professional license, if held _____

State of License _____ Professional License Number _____

Area of Specialization _____

Applicant's supervised practice location (facility name and address): _____

_____

L. Please state the quality of the applicants performance during the supervised practice period:
_____
_____
_____
_____
_____
_____
_____
_____

M. I have reviewed the applicant's statements. They ☐ are **or** ☐ are not substantially correct.

N. As supervisor, do you have any reservations about the applicant being granted a license? ☐YES ☐NO

IF **YES**, PLEASE SPECIFY (Attach additional sheet if necessary):
_____
_____
_____

_____
Signature of Supervisor

State of _____, County of _____, ss.
Subscribed and sworn before me this _____ day of _____, 20 _____.

_____
(seal) Notary Public official signature
commission expires_____

NOTICE TO SUPERVISOR

Please seal BOTH PAGES of this completed document in an envelope, sign your name across the sealed back flap, and return it to the applicant.